PSYCHOLOGY CASE RECORD

Submitted to the Tamil Nadu Dr. M.G.R. Medical University in partial fulfilment of the requirements for the Diploma in Psychological Medicine Examination 2015

By
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Most of all, I would like to thank The Almighty God for his Grace.

CERTIFICATE

This is to certify that this Psychological Case Record is a bonafide record of work done by **Dr. RAVI SUNIL** during the year 2013-2015. I also certify that this record is an independent work done by the candidate under my supervision.

Dr, Anna Tharyan,
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CASE RECORD 1: Personality Assessment

Name : Mr.MC

Age : 34 years

Sex : Male

Marital status : Married

Religion : Hindu

Language : Telugu and Tamil

Education : MBA graduate

Occupation : Manager

Socio-economic status : Upper

Residence : Semi Urban

Informant : Mr.MC and his wife

Presenting complaints

Adamant & Oppositional behaviour - twenty years duration

Excess intake of alcohol - fifteen years duration

History of presenting illness

Mr.MC presented with consumption of alcohol for last 15 years and in dependence pattern for last 7 years. There has been a gradual increase in the amount of alcohol consumed over the years with Mr.MC currently consuming about 360 ml of hard liquor per day. He also reports of increased desire to seek for alcohol when he gets frustrated._ He is unable to cut down his alcohol intake and tends to be preoccupied about how to procure alcohol resulting in not spending time with family members. He predominantly drinks with his friends and his cousins. He also drinks during daytime alone. He also has poor frustration tolerance levels and adamant behaviour leading to increased anger outbursts for trivial issues at home resulting in destructive behaviour such causing damage to house hold things objects and mobile phones. There is also abusive behaviour towards family members including wife leading marital problems between them. His self-care and biological functions are intact. However there was impairment in socio-occupational functioning. There is no history of any suicidal attempts or ideas, medical, legal or social complications secondary to alcohol consumption. There is history suggestive of nicotine in harmful use pattern and benzodiazepine abuse.

There is no history of any medical complications such as hematemesis, melena or jaundice. There is no history of any complicated withdrawal.

There is no history suggestive of first rank symptoms.

There is no history of depressive syndrome or mania or hypomania.

There is no history of phobia or panic attacks.

There is no history suggestive of organicity or seizures.

Treatment history

There has been no prior treatment for alcohol de-addiction. He is a known diabetic and hypertensive and is on treatment for the same.

Family history

He is the eldest of two siblings. There is family history of alcohol dependence syndrome in his cousin and uncle. There is no family history of any other neuropsychiatric morbidity.

Developmental history

The antenatal period was supervised and uneventful. Delivery was full term normal vaginal; with no birth asphyxia or neonatal seizure. Postnatal period was uneventful. His motor and language developmental milestones were reported to be normal.

Educational history

He has completed his Master's in Business Administration (MBA). His academic performance overall is reported as average.

Sexual history

He had male gender identity and heterosexual orientation. He described his libido as normal and he denied the presence of sexual dysfunction. He also denied any high risk sexual behaviour.

Marital history

He is married for the past four years to Ms. S who is 28 years old and is the principal of a school. He does not have any children yet. There is history marital difficulties secondary to his alcohol use.

Premorbid personality

He was described to have low frustration tolerance, immediate gratification of needs and a tendency to be oppositional. He was not a religious person and was dominant overall in his approach towards people. He had difficulty in maintaining relationship due to his low frustration tolerance

Physical examination

His vitals were stable with blood pressure of 160/80 mm of Hg. His systemic examinations were within normal limits. There were no signs of liver cell failure or cerebellar signs.

Mental status examination

He was a well built and well kempt individual. He maintained good eye contact. Rapport was easy to be established. There was no restlessness. There were no abnormal involuntary movements. He was co-operative during interview. His speech was of normal tone, pitch, reaction time and speed. His mood was euthymic with normal range and reactivity of affect. He denied any suicidal ideas. There were no abnormalities in the form and stream of thought. He denied the presence of delusions or depressive ideations. There were no perceptual abnormalities reported. There were no obsessions or compulsions. He was oriented to time, place and person. His attention could be aroused and was sustained. His immediate, recent and remote memory was intact. His intelligence was average and his judgement was intact. He had an internal locus of control and he was in contemplation stage of motivation.

Provisional diagnosis

ALCOHOL DEPENDENCE SYNDROME-CURRENTLY ABSTINENT

NICOTINE – HARMFUL USE

HYPERTENSION

DIABETES MELLLITUS

Aim for psychometry

To identify and explore significant personality factors influencing the psychopathology

Tests administered

1. 16 Personality Factors Questionnaire
2. Sentence Completion Test
3. International Personality Disorder Examination (IPDE) ICD 10 module screening Questionnaire

Behavioural observation

During the entire period of assessment, he was cooperative. He could comprehend the instructions and paid adequate attention. He appeared well motivated.

Rationale for the tests

16 Personality Factors Questionnaire was developed by Raymond Cattell and it measures the 16 primary personality traits and the Big Five secondary personality traits.

Test findings

The 16 PF indicates that Mr. MC has low frustration tolerance and expresses his anger irrespective of the situation. He tends to be emotional and temperamental over trivial issues and reacts strongly to stress. He may overreact to interpersonal stress and often lose his cool resulting in strains in his relationship with others. He tends to be dominant in his attitude and communication with others. He may come across as aggressive and intimidating to his subordinates due to his attitude and He tends not to respect others' opinions and asserts his own on them. He tends not to conform to accepted social standards and to do things his own way. He tends to be vigilant and suspicious in nature and is often skeptical of others. He may be resentful and hold grudges with others. He tends to be very self-confident to the point of being considered arrogant. He may lack guilt over his actions and tends to not be overly bothered by criticism.

Sacks Sentence Completion Test is a projective test developed by Dr.Sacks and Dr.Levy. It consists of 60 partially completed sentence to which respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self-perception.

Test findings

His attitude towards his mother indicates regret about not being able to keep her happy. He appears to hold his father in high regard. Although he feels that his family has been supportive of him though his problems, he feels that they are financially and socially at a lower level. He appears to have a patriarchal view about women. He expresses distrust towards his friends that they talk behind his back. His attitude towards his subordinates is positive. There is significant regret expresses regarding major decisions that he had taken in his life in the past. However, despite this, he expresses an optimistic view about his future that he would become successful someday.

The **IPDE** developed by Dr.Armand B. Loranger and colleagues is a semi structured interview that provides a means of arriving at the diagnosis of major categories of personality disorders and of assessing personality traits in a standardized and reliable way it is unique in that it secures reliable information in different cultural settings.

Test findings

The IPDE indicates the presence of prominent impulsive, borderline and paranoid traits.

Conclusion

The psychological assessment indicates the presence of predominant traits of impulsivity, low frustration tolerance, paranoia and dominance. He tends to react strongly in stressful situations. He appears to have distrust towards people in general resulting in him not able to sustain relationships although he is skilful in making relationships. The low frustration tolerance, impulsivity confirms the presence of impulsive traits in Mr. MC.

Management

He was primarily admitted for de-addiction in a protected environment. Rapport was established with the patient and the family. His family was allowed to ventilate and was psycho educated about the nature, course and prognosis of his illness. Family dynamics, structure and communication patterns were explored. Motivation enhancement therapy was employed and various relapse prevention measures and environmental modification strategies were discussed. Anger management, relaxation and problem solving techniques were taught.

Case study 2: Intelligence Assessment

Name : D D

Age : 3 years 3 months

Sex : Female

Education : Kindergarten

Informant : Parents

Reliability : Good

Presenting complaints

Speech regression from 2 years of age.

Repeatedly looking up to fan.

Solitary play.

History of presenting complaints

Baby DD was brought by her parents who reported that she had normal developmental milestones till 2 years of age when she gradually started showing regression in the language skills. She was also noted to repeatedly look up towards the fan without any other sign suggestive of seizure activity. History of solitary play was present although she

could do other self-care activities appropriately. Biological functions were intact, however there was impairment in her social and academic functioning.

Past history

History of Dengue at the age of 1&1/2 years for which she had been treated elsewhere.

Birth and development history

Prenatal: Planned pregnancy with uneventful antenatal period

Perinatal: Full term normal delivery at hospital with birth weight 2.7 Kg who cried soon after birth.

Postnatal: uneventful neonatal period and breast fed upto 2 years of age. She was immunised for age.

Milestones of development

Motor : Had been normal. Curently can walk, run and climbs stairs with support.

Speech and language: Babbling by 7 months, Bisyllable by 9 months. She had 10 – 12 meaningful words till 2 years. Currently there is a regression in her spontaneity in using words.

Play skill: enjoys solitary play, however there are difficulties with imitative and associative play.

Socialization: Prefers to stay in the company of family members in familiar surroundings.

Self help: She cries and points to feeding bottle when hungry and is able to eat on her own.

Drinking is independent. She is able to indicate for her toilet needs by pulling at her pants and crying. Cooperates for dressing, attempts to brush with assistance and applies soap and pours water while bathing.

School history : She started at 3yrs and 2 months in an English medium school however attended for only one month.

Behavioural problems: Repetitive behaviour of repeatedly watching fan and constantly preferring to be in moving vehicles.

Comorbidities: Nil

Family history : Nil significant.

Physical examination

Her vitals were stable and systemic examination was within normal limits.

Mental status examination

She is moderately nourished and well kempt child. Her motor activity was purposeful and appropriate with no abnormal movements. She was mute and did not use appropriate non verbal communication. Eye contact was poor. She showed selective attention towards her environment. Her interest towards toys and materials was better than towards people.

Provisional diagnosis

UNDIFFERENTIATED DEVELOPMENTAL DISABILITY

BEHAVIOURAL PROBLEMS.

Aims of psychological testing

To assess and quantify her developmental age and functioning and to rule out other developmental disabilities.

Tests administered

1.Gessel's Developmental Schedule (GDS)

2.Vineland Social Maturity Scale (VSMS)

Rationale for the tests

1. VSMS was used to assess the social adaptation and social age
2. GDS is a developmental schedule which looks at 5 domains namely, Adaptive, Gross motor, Fine motor, Language and Personal & Social.

Behavioral observation

Baby DD was not-cooperative for the testing. She was able to comprehend instructions. She was attentive but not able to sustain it. She was found to rub objects and clap her hand frequently. Repeated looking towards the fan was present. No hyperactivity or anxiety was observed.

Test findings

Gessel's Developmental Schedule:

Adaptive: 14months

Gross motor: 18 months

Fine motor: 12 months

Language : 8 months

Personal & social:9 months

Developmental quotient **(DQ) =63**

Vineland Social Maturity Scale

The social age of DD was 1.63 years, which was low for her age. The profile of age levels across the functions were as follows:

Communication: 0.55 years

Self help eating: 1.65 years

Self help dressing: 1.13 years

Self help general: 2.85 years

Occupation: 1.10 years

Locomotion: 1.75 years

Socialization; 1.50 years

Impression: Mild level of developmental disability with behavioural problems.

Pervasive Developmental Disorder (PDD)

Management

1. The parents were educated about her condition and the need for long term care and training.
2. Speech and behavioural therapy was suggested.
3. The need for special education was also stressed.

4. Parents were encouraged to attend the 12 week parent training program for further management of the child.
5. Genetic and parental counselling.

Referral for hearing, vision and neurological evaluation

CASE RECORD 3: Diagnostic Clarification

Name	: Ms.RT
Age	: 21 years
Sex	: Female
Marital status	: Unmarried
Religion	: Muslim
Language	: Urdu, English
Education	: BSC completed
Occupation	: Currently unemployed
Socio-economic status	: Middle
Residence	: Semi urban
Informant	: Ms.RT and her parents

Presenting complaints

Irritable and abusive and violent behaviour - ten years duration.

History of presenting illness

Since childhood, Ms RT is described to be adamant and short tempered. As father stayed away from her home due to his occupation, she had difficulty adjusting to it and her mother expressed difficulty in bringing her up. She is reported to be aloof even during her school days and had few friends and rarely spent time with them. She preferred solitary activities and her interaction with her family members was also poor.

She is also reported to be overly dependent on her parents for trivial things and when they were not done as she pleased, she threw temper tantrums and her tolerance for frustration gradually reduced. She is described to be impulsive in her actions often and occasionally engaged in destructive behaviour such as breaking household articles and electronic gadgets.

However, she is reported to be very quiet outside the house and expresses anxiety in social situations resulting in her avoiding such situations.

Her self-care is reported by parents as poor and would not change her clothes often. There are instances reported suggestive of attention seeking such as preoccupation with unexplained physical complaints. There is history of suicidal attempts of low intentionality and lethality in the past following stressors. Her biological functions are reported to be disturbed.

There was no history of any abnormal perception.
There was no history of depressive syndrome or mania or hypomania.

There was no history of phobia or panic attacks.

There was no history suggestive of organicity or seizures.

There was no history of substance use.

There was no history of conduct disorder or pervasive developmental disorder.

There was no history of repetitive behaviours.

Treatment history

She was evaluated for physical complaints at multiple clinics and many investigations were done which were all negative for abnormal findings.

Family history

She was the elder of two siblings. There was no history of any neuropsychiatric morbidity in the family.

Developmental history

The antenatal period was supervised and uneventful. Birth was full term normal vaginal delivery with no birth asphyxia or neonatal seizure. Postnatal period was uneventful. The developmental milestones were reported to be normal.

Educational history

She has completed her Bachelor's degree in visual communications and her academic performance was described as average. She did not have many friends and her relationship with her teachers was poor.

Sexual development

She has female gender identity and has heterosexual orientation. She attained menarche at the age of 12 years and has normal menstrual cycles.

Marital history

She was unmarried

Premorbid personality

She had few friends and tends to remain away from others. She preferred solitary activities. Her extracurricular interests were limited. She had poor moral and religious standards.

Physical examination

Her vitals were stable. Systemic examinations were within normal limits.

Mental status examination

She was moderately nourished, well kempt individual with good eye contact. She maintained a normal posture and motor activity was limited but appropriate and purposeful. Her speech was normal with increased reaction time and relevant. Her mood was euthymic with restricted range and decreased reactivity of affect. Her content of thought revealed beliefs of being looked inferiorly by others in terms of her short stature and her interest in studies which was not common in their culture. No thought alienation phenomena or perceptual abnormalities were present. She was oriented to time, place and person. Her attention could be aroused and sustained. Her memory functions were intact. Her intelligence was average. Her insight in her problems were partial and her judgement was intact.

Provisional diagnosis

MIXED PERSONALITY DISORDER – Impulsive and anxious Traits

PRODROME OF SCHIZOPHRENIA.

Aim for psychometry

To clarify symptomatology, psychopathology and diagnosis

Tests administered

1. Rorschach Inkblot test
2. Thematic Apperception Test
3. Sentence completion test

Behavioural observation

She was cooperative for the assessment. Her attention could be aroused and she was able to sustain her attention over the course of the assessment. She was able to comprehend instructions well and was able to communicate adequately. There was mild anxiety observed initially. However, gradually, her anxiety subsided.

Rationale and Findings

Rorschach Ink Blot Test provides an understanding of structure of the personality, affectional needs and ego strength. It also indicates degree of psychopathology.

Test findings

On the protocol she had given 16 responses. It reveals low productivity with normal mentation. She tends to repress her impulsivity life in favour of conscious values which may result in the presence of conflicts, inner tension and excessive control. The protocol indicates that although she is capable of a more richly differentiated response, she is inhibited due to repression of tendencies to acknowledge and respond to her own inner needs and act according to her own emotional reactions. She tends to be inhibited in conditions of strong environmental impact. She appears to be disturbed by emotional impact from the environment. She has a tendency to withdraw from the environment as she may feel threatened by it. There is an underdeveloped need for affection suggesting difficulties in interpersonal relationships. Poor sensitivity to shading indicates repression in the need to form interpersonal relationships. . The high number of unrealistic human content indicates social anxiety and reiterates her tendency towards social isolation. There is a high percentage of animal responses indicating narrow range of interest and adjustment difficulties. Although there are only 4 popular responses provided, it does not indicate loosening of ties with reality as the total number of responses is only 16 and the percentage of popular responses will be 40. Low sum C score indicates a lack of responsiveness to the environment.

Thematic Apperception Test is a projective measure intended to evaluate a person's patterns of thought, attitudes, observational capacity, and emotional responses to ambiguous test materials. It elicits information about a person's view of the world and his attitudes toward the self and others.

Test findings

The stories are detailed in their description and well structured. The predominant needs seen in the stories are need for achievement, need for autonomy, need for aggression. The

dominant conflicts seen are need for rejection vs need for affiliation and need for achievement vs need for deference. She identifies herself with all the female heroes of the stories. The female heroes are portrayed as hard working, resourceful and persevering against all odds and finally achieving success. The major press seen are poverty and societal norms. The male characters are portrayed as dominant and aggressive and with aggressive tendencies. The defences used are projection and reaction formation in the stories.

Sentence Completion Test

Test findings

Her attitude towards her mother is neutral although she reports that she does not like the constant advice, her mother gives. She has a positive attitude towards her father and does not indicate any conflict with him. However, she feels that she is not treated well by the family as a unit and that despite her educational status, is not treated accordingly. There is regret regarding her past performance, she expresses confidence about her ability to succeed in the future provided circumstances are beneficial. She tends withdraw when odds are against her. She has conflicts with superiors and tends to get frustrated when advised or criticized. Her attitude towards subordinates is positive. She expresses disgust regarding the romantic nature of heterosexual relationships and expresses that marriage involves more than satisfaction of the physical desires. Ms. R appears to be self-confident and at the same time expresses difficulty in persevering against opposition. She has contemporary outlook towards specific areas of life and reserves orthodox views regarding other areas such a marriage and family ties.

Conclusion

The psychological assessment did not reveal any indicators of psychosis or mood syndrome at present. Assessment reveals the presence of anxious and impulsive traits suggestive of personality component.

Management

Routine investigation including imaging was done which were in normal limits, and she was started on low dose Risperidone for control of irritability. Rapport was established with her and she her distress regarding her problems at home and at college were acknowledged. Further sessions were planned to explore her attitude towards family and socialization and help her develop trust and relations within the family and with college friends. Help her to cope with anger and to teach stress management strategies. Serial mental status examinations will be done to watch for any abnormal psychopathology, and to address them.

Parents were allowed ventilation and psychological support was provided to them. They were explained about the nature, course and the prognosis her condition. The personality factors and both Ms. RT and their role in therapy was explained to them.

CASE RECORD 4: Diagnostic Clarification

Name : Ms ST

Age : 32 years

Sex : Female

Marital status : Unmarried

Religion : Hindu

Language : Telugu/Hindi/English

Education : MCA

Occupation : student

Socio-economic status : Middle

Residence : Semi-urban

Informant : Self, elder sister and father

Presenting complaints

Suspiciousness - 10 years duration

Persecutory beliefs - 10 years duration

History of seizures - 14 years back

History of presenting illness

Ms ST was reportedly well till ten years back when she began to express suspiciousness that her coworkers were exploiting her and were making fun of her. Gradually she began to express that unknown people also were taking about her and making fun of her. She also began to express persecutory delusions that people were trying to harm her at her work place and elsewhere. She held these beliefs with conviction despite lack of proof for them. She began to express that she was able to see nonexistent objects such as spirits and expressed fearfulness secondary to this. Following this, there was a gradual decline in her self-care and she began to require prompts for her self-care. She stopped going for work and began to stay at home. She expressed fearfulness to go out of the house due to her delusions. Her biological functions were impaired. She underwent treatment from a private psychiatrist and showed improvement in her symptoms and was doing well for eight years. Despite the improvement, residual psychotic symptoms persisted and she never attained her premorbid level of functioning. Her compliance to medications was adequate. However, secondary to side effects of her medications, she stopped medications for the last 3 months. Since the last one month, there is history suggestive of a relapse with assaultive behaviour and disturbed biological functions, with further worsening over the last seven days characterized by decrease in socialization, hallucinatory behaviour, disorganized behaviour such as attempting to cut her hair by self for no specific reason, decline in self-care and suicidal ideations.

There is history suggestive of seizures characteristic of generalized tonic-clonic seizures fourteen years back. These seizures continued for 3 years and subsided after treatment with anti-epileptics. During this period there was no history suggestive of any psychotic symptoms. She has been seizure free for the last twelve years.

There was no history suggestive of head injury.

There was no history suggestive of substance misuse.

There was no history of depressive syndrome or mania or hypomania.

There was no history of anxiety, phobias or panic attacks.

There was no history suggestive of obsessive-compulsive behaviour.

Treatment history

She has had trial of Tab Risperidone Tab. Olanzapine and Tab. Aripiprazole in sub therapeutic doses at various periods in the past. She was treated with Tab. Carbamazepine for her seizures. Her compliance to medications was adequate for eight years. However, following side effects of amenorrhea and her desire to get married, she discontinued medications three months back.

Family history

She is the third of three daughters. There is history of completed suicide in the maternal aunt and the reasons for the suicide were unclear.

Developmental history

The antenatal period was supervised and uneventful. Delivery was full term normal vaginal; with no birth asphyxia or neonatal seizure. Postnatal period was uneventful. The developmental milestones were reported to be normal.

Educational and Occupational history

She has completed her Bachelor's Degree in Computer Science and a Master's Degree in Computer Applications.

Sexual development

She had female gender identity and heterosexual orientation. She denied any high risk sexual behaviour or sexual dysfunction. She had irregular menstrual cycles.

Marital history

She was unmarried.

Premorbid personality

She had good social interactions. But was an introvert, She was reportedly responsible towards work and studies and had high moral and religious standards and.

Physical examination

Her vitals were stable. Systemic examinations were within normal limits.

Mental status examination

She was moderately built and nourished. She was dressed appropriately. She avoided eye contact. There was psychomotor retardation. She remained mute and did not interact with the examiner during the initial interviews. She had a blunt affect. Abnormalities in form, stream and content of thought could not be assessed initially. However, subsequent interviews revealed absence of formal thought disorder and persecutory and referential delusions. Hallucinatory behaviour could be observed. She was not cooperative for assessment of cognitive functions initially. However subsequent interviews revealed intact orientation, attention and memory. Her intelligence was average and her judgment was impaired. She had poor insight into her illness.

Provisional diagnosis

PARANOID SCHIZOPHRENIA - CONTINOUS COURSE

ORGANIC PSYCHOSIS SCHIZOPHRENIA LIKE

SEIZURE DISORDER

Aim for psychometry

To clarify symptomatology, psychopathology and diagnosis

Tests administered

1. Rorschach Inkblot Test

2. Sentence Completion Test

3. Positive and Negative Syndrome Scale

Behavioural observation

She was cooperative for the assessment. Her attention could be aroused and she was able to sustain her attention over the course of the assessment. She was able to comprehend instructions well and was able to communicate adequately.

Rationale and Findings

Rorschach Ink Blot Test provides an understanding of structure of the personality, affectional needs and ego strength. It also indicates degree of psychopathology.

Test findings

In the Rorschach protocol she has given 15 responses indicating that quantitative scoring can be done. It reveals low productivity with average mentation. The protocol indicates an underdeveloped need for affection. It reveals a natural constriction in his personality indicating a basic defect in the organization of her personality and lack of emotional depth. The emotional reactivity dimension indicates that there is minimal interest in seeking

relationships. The need to have stable, dependent relationships is poorly developed. There appears to be an overly high level of aspiration without the adequate resources to meet them. There is an inability to look at things in an integrated manner. High animal percentage indicates a tendency to look at things in a stereotypical manner and adjustment difficulties. DW response and the lack of popular responses indicate poor ties with reality.

Sacks Sentence Completion Test is a semi projective test developed by Dr Sacks and Dr Levy. It consists of 60 partially completed sentence to which respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self-perception.

Test findings

There are no conflicts in her attitude towards her mother. However, she feels that her father is not understanding or supportive of her. Although she expresses that her family treats her as an immature individual, she considers her family better than most. She expresses positive attitude towards women in general but does not consider herself equivalent to other women. She is not dominant and is rather polite and prefers to treat her colleagues and subordinates as her friends. She is guarded about her past regrets but expresses optimism about looking forward to the future.

Positive and Negative Syndrome Scale (1987) is a rating scale developed by Kay and colleagues for measuring the severity of symptoms in schizophrenia. It consists of a positive and negative syndrome scale that have 7 items each and a general psychopathology scale that has 16 items. The items are rated on a Likert type scale ranging from 1 to 7 the higher scores indicating greater severity of the symptoms.

Test results

She obtained a score of 25 in the positive syndrome scale, 16 in the negative syndrome scale and 23 in the general psychopathology scale. Her total score is 64. She had high scores in the domains of Delusions & Suspiciousness/ Persecution and moderately severe scores on excitement, and unusual thought content domains.

Conclusion

The protective testing has clear indicators suggestive of schizophrenia and there were no signs suggestive of any organicity seen. The testing indicates her poor touch with reality. The rating scale also suggests the presence of a functional illness.

Management

Her symptoms were well controlled with Tab.Olanzepine and for seizure control she was advised to take Tab.Phenytoin, rapport was established and encouraged her to participate in physical activity as well as in occupational therapy. She was allowed to develop insight into her illness and stressed on compliance and regular follow-ups along with other psychosocial issues like future career and handling complications during the illness. Parents were explained about the nature, course and the progress of the illness and the need of compliance, and were allowed to ventilate.

CASE RECORD 5 – Neuropsychiatric assessment

Name : Mr.I

Age : 51 years

Sex : Male

Marital status : Married

Religion : Hindu

Language : Tamil/Hindi

Education : ITI

Occupation : Fitter and welder in mines

Socio-economic status : Middle

Residence : semi urban

Informant : Mr I, his brother in law and friend

Presenting complaints

Behavioural change - six months

Mode of onset – insidious

History of presenting illness

Mr I was apparently well till six months back when he had an accident while he was working in the mines and sustained a head injury with loss of consciousness. Neurological evaluation revealed an injury to the basal parts of the frontal lobe and he underwent neurosurgery. Following the surgery, he developed brief period of amnesia and unawareness

but regained his memory later. However, he began to gradually manifest behavioural abnormalities such as increased irritability towards family members, disinhibited behaviour towards women including attempts to make physical contact with them; making fun of others without any provocation; and crossing the signals while walking on the roads; over familiarity towards strangers with Mr. I smiling inappropriately at co passengers while travelling or even at the strangers on the road.

Although there is increased irritability towards his family member and makes threats about assaulting them physically, there have been no instances of physical assault reported. His biological functions are normal. He is independent in his activities of daily living.

There is a history of nicotine use in dependence pattern for more than twenty five years.

There is no history of any other substance use.

There is no history of apathy.

There is no history of difficulty in speech.

There is no history of apraxia or difficulty in calculation.

There is no history suggestive of psychosis or syndromal depression or mania.

There is no history of obsessions or compulsions or phobia or panic attack.

Past history

There was no past history of any other neuropsychiatric morbidity. He has no medical comorbidities.

Family history

He is the fourth of five siblings. There is no history of any neuropsychiatric illness in the family.

Birth and development history

The antenatal period and was uneventful. The birth was at full term normal vaginal delivery. There was no birth asphyxia. The developmental milestones were reported to be within normal limits.

Educational history

He has completed ITI. He was described to be average in academics. His relationship with his peers and his teachers was warm.

Occupational history

He has been working in Uranium Corporation of India, Jharkhand as a welder and a fitter for the last 20 years.

Sexual history

He has male gender identity and heterosexual orientation. He reported of increased libido. He denied the presence of sexual dysfunction or high risk sexual behaviour.

Marital history

He is married to Ms S, who is a home maker, for the last 18 years. He has three daughters aged 16 years, 14 years and 7 years.

Premorbid personality

He was described to be a well-adjusted personality without any deviant traits and was responsible towards work and his family.

Physical examination

His vitals were stable. There was no pallor or lymphadenopathy. His cardiovascular system examination, respiratory system examination and gastrointestinal system examinations were normal. There was an indentation on the frontal region of the head.

Central nervous system

Cranial nerves – No cranial nerve deficits

Motor system

Bulk - Normal bilaterally

Tone - Normal tone bilaterally

Power - Grade 5 power bilaterally

No involuntary movements

Sensory system

Crude touch, Pain, Temperature - Normal bilaterally

Light touch, Vibration and Joint position sense - Normal bilaterally

Reflexes

Superficial abdominal reflex - Present all four quadrants

Plantar reflex - Flexor bilaterally

Deep tendon reflexes - 2+ bilaterally

Cerebellar functions - No signs of cerebellar dysfunction

Gait - Normal

Meningeal signs - Absent

Skull and spine – there is an indentation on the frontal region of the head.

Mental status examination

He was moderately built and nourished, and was adequately kempt. He maintained eye contact. Rapport was established with ease and he behaves very familiarly. There were no abnormal involuntary movements. His speech was spontaneous, fluent, audible with normal speed and reaction time and relevant. His mood was euthymic with normal range and reactivity of affect. He denied suicidal ideation. There was no formal thought disorder. He denied delusions and depressive cognitions. He denied having any perceptual abnormalities. There were no obsessions and compulsions. His abstract thinking was normal. His recent and remote memory was intact. His immediate memory was impaired. Attention could be aroused but was difficult to sustain. He was oriented to time, place and person. His intelligence was average. He had adequate insight into his illness.

His personal and test judgment were intact. However, his social judgement was impaired.

Provisional diagnosis

ORGANIC PERSONALITY DISORDER

NICOTINE DEPENDENCE SYNDROME -- ACTIVE DEPENDENCE

Aims for neuropsychological testing

1. To find out the cognitive profile of Mr I
2. To relate the findings to clinical presentation

Tests administered

1. NIMHANS Neuropsychological Battery

Rationale and findings

NIMHANS Neuropsychological Battery (2004) –

Description of the tool – The battery was developed by Shobini Rao et al. This tests a subject's performance across lobe functions. It has been validated to suit the Indian adult population between the ages of 16 -65. It comprises of a series of subtests that assess the following domains:

Speed (motor and mental), Attention, Executive functions, Comprehension, Verbal learning and Memory, Visuo-spatial construction & Visual Memory.

Test findings

Mental speed

On the digit symbol substitution test, the total time taken to complete was 478 seconds which is below the 3rd percentile, indicative of significant impairment in mental speed.

Sustained attention

On the digit vigilance test, the total time taken to complete was 1800 seconds which is below the 3rd percentile. The total errors (commission and omission) is 153 which is less than 3rd percentile, indicative of significant impairment in sustained attention.

Focused Attention

The total time taken to complete Trail Making Test A and Trail Making Test – B were 126.3s and 498s respectively. Both indicative of significant impairment in focused attention.

Divided Attention

On the Triads Test, the total errors was 7, which is at the 8th percentile, indicative of impairment in his ability to divide attention between two tasks. He was able to focus his attention on only one out of the two tasks he was instructed to do.

Executive functions

- **Phonemic fluency**

  Phonemic fluency was assessed by the Controlled Oral Word Association Test (COWAT). On the COWAT, the average new words generated was 13.34 which is at the 50th percentile and is indicative of intact phonemic fluency.

- **Categorical fluency**

  It was assessed by the Animal Names Test. The average new words generated were 10, which is below the 10th percentile, indicative of impairment in categorical fluency.

- **Planning**

  Planning was assessed by the Tower of London Test. The total number of problems solved in the minimum number of moves is 12, which is at the 90th percentile. The mean time taken, the mean moves and the number of problems solved with minimal moves are as follows,

No of moves	Time taken	Percentile	Mean moves	Percentile	No of prob with minimal moves
2 moves	6.3s	13th	2	100th	2
3 moves	15.9s	30th	3	100th	4
4 moves	47.5s	3rd	5.5	57th	3
5 moves	32.4s	27th	6	73rd	3

The scores suggest minimal impairment in problem solving ability. There is fluctuation in the score which could be due to poor attention as the patient was able to conceptualize the problem and avoided making similar errors.

Verbal Learning and Memory

On the auditory verbal and learning test, the total number of correct words recalled is 30, which is less than 5th percentile; the immediate recall and delayed recalls are at 6 and 5 words which are both below the 5th percentile. The long term percentage retention is 71.4%. The number of hits in the recognition trial is 9 which is below the 5th percentile. This indicates the presence of deficits in verbal learning and memory. His recognition also is impaired.

Visuo- spatial construction and visual learning and memory.

On the ROCF, the copying score is 29, which is the 10th percentile. The immediate recall score is 20.5 and the delayed recall score is 20.5 which are at the 40th percentile and 50th percentile respectively. This indicates impairment in visuo-constructive ability but intact visual memory.

Conclusion

The test findings suggest the presence of significant deficits in the areas of complex attention, verbal fluency and verbal learning and memory. His comprehension is fair and his impairment in visuo constructive memory was mild. There were fluctuations in his problem solving ability which may be due to impaired attention. The overall findings indicate fronto-temporal deficits.

Management

Mr. I and his family were educated about the nature, course and the prognosis of the illness. He was started on low dose antipsychotic medication for control of behavioural symptoms and was asked to review for long term monitoring. Parents were educated about behavioural techniques to manage his behaviour in public and Mr. I was also educated about the possible consequences of his disinhibited behaviour. Strategies for anger management, and relaxation techniques were discussed with him.